BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE FACTORS IN THE BACKGROUNDS OF CHILDREN FROM THE SAME FAMILIES WHO HAVE BEEN REFERRED TO A CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

Purpose

This is a study of children coming to a child guidance clinic from the same families to determine, if possible, what there is in their backgrounds that makes it necessary for more than one child to come to the clinic for treatment. So often one hears parents ask, "Why should Jimmy or Mary be different from the rest of the family? We treat them all alike. They are all equal." But, are they? They have the same parents and possibly the same physical environment, yet there are many factors which are different. Sex, ordinal position and intelligence are but a few. Parental attitudes differ considerably because of identifications, changes in family situations or even the health of the child. The writer poses these questions. What are the factors in the background of these siblings? Are they the same? Are the same influences at work in each case? Do siblings respond to these influences with the same behavior and personality patterns and if not, why not? The writer is not going into a discussion of heredity versus environment or an attempt to differentiate between hereditary and environmental factors. The relationships of the child to his parents, siblings and others will be considered. It is the purpose of this thesis to try to determine what the individual background of each child is, how these factors in the backgrounds of these siblings affect their behavior and personality development and

CHAPTER I

INTRODUCTION

Purpose

This is a study of children coming to a child guidance clinic from the same families to determine, if possible, what there is in their backgrounds that makes it necessary for more than one child to come to the clinic for treatment. So often one hears parents ask, "Why should Tiny or Mary be different from the rest of the family? We treat them all alike. They are all equal." But, are they? They have the same parents and possibly the same physical environment, yet there are many factors which are different. Sex, ordinal position and intelligence are but a few. Parental attitudes differ considerably because of identifications, changes in family situations or even the health of the child. The writer poses these questions. What are the factors in the background of these siblings? Are they the same? Are the same influences at work in each case? Do siblings respond to these influences with the same behavior and personality patterns and if not, why not? The writer is not going into a discussion of heredity versus environment or an attempt to differentiate between hereditary and environmental factors. The relationships of the child to his parents, siblings and others will be considered. It is the purpose of this thesis to try to determine what the individual background of each child is, how these factors in the backgrounds of these siblings affect their behavior and personality development and

what is the result of the interplay of the personality and background factors of these children.

Method and Scope

These cases have been taken from the files of the Child Guidance Clinics operated by the Division of Mental Hygiene of the Massachusetts Department of Mental Health. The cases used in this study were selected on the basis of criteria described below without selection as to clinics, so that the following clinics are represented: Brockton, Boston Dispensary, Quincy, Lowell and New England Hospital. There are no cases from the West End Clinic. The case material includes the reports of the social worker, psychiatrist and psychologist.

Criteria for Selection

1. Cases in which another sibling was known to the clinic.
2. Cases with a full social history to give sufficient background material.
3. "Closed" cases, those in which treatment has been terminated.

The calendar year from January 1 to December 31, 1943 was selected because it was the most recent year in which there would be sufficient "closed" cases with which to work. Recent cases are desirable because they contain fuller data and "closed" cases so that the picture of relationships and attitudes can be evaluated. Of the total thirty-nine cases in which there was another sibling opened during 1943, twelve were selected for this study on the basis of the above criteria. Of the remaining twenty-seven cases, ten came only for

psychological appraisal for child-placing agencies and schools; seven, for diagnosis only; and the other ten were either still open or short term cases in which a full history was not taken.

Of the twelve cases selected, ten have one other sibling known to the clinic, while two cases have two other siblings known, making a total of twenty-six children in the twelve families. Seven of these siblings are not full-treatment cases but there is sufficient material for study purposes.

In the course of this study the writer has examined many books and magazine articles but has been unable to find any written material pertaining to the subject of what brings more than one sibling to a child guidance clinic for treatment.

Limitations

In all but one of these cases, according to clinic practice, the social history and fullest emphasis is upon the first sibling referred, with less material available on the subsequent children seen. While the writer realizes that a study of twelve families cannot produce reliable statistical evidence, there are common factors and certain trends and indications in these cases which can be studied and which may interest others in future studies with a broader scope.

Limitations

CHAPTER II

MASSACHUSETTS CHILD GUIDANCE CLINICS: THEIR DEVELOPMENT AND FUNCTION[1]

Child Guidance Clinics are community clinics for the study and treatment of children who manifest habit and behavior problems which interfere with a normal development and adjustment. Assistance with the problems of child training and personality development is also offered. The program of the clinics is one of Prevention, prevention of the difficulties which may arise later in life because the treatment of early childhood behavior problems was neglected.

The Mental Hygiene Movement, which was introduced in America during the twentieth century, grew by leaps and bounds after World War I as people began to understand the contributions of the study of psychiatry. With the emphasis being laid more and more on the formative years of a child's life, the Child Guidance Movement came into being. Early in the 1920's, there were a few experiments throughout the country in mental hygiene clinics, especially for children, but these were mostly connected with the courts, dealing with delinquent children, and the results were not too successful. However, they did indicate possibilities for the treatment of other types of maladjusted children.

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1 Edgar C. Yerbury and Nancy Newell, "The Development of the State Child-Guidance Clinics in Massachusetts," New England Journal of Medicine, 233:145-153, August 2, 1945.

In 1919, Massachusetts passed a law requiring the examination of all children who were three years retarded in school and the establishment of special classes where there were ten or more such children found.[2] Examination was furnished by the state hospitals and schools for the feeble-minded by means of clinics distributed through the State which came to be known as the "traveling school clinics". State hospitals also started outpatient mental hygiene clinics with services for both adults and children.

In 1921, Dr. Douglas A. Thom made a survey in Boston at the request of the Baby Hygiene Association of Boston which resulted in the establishment of what is probably the first clinic for psychiatric treatment of very young children. Three clinics were established under the auspices of The Community Health Association and were given the name of "habit clinics".

In 1922, the Commonwealth of Massachusetts established by legislation a Division of Mental Hygiene,[3] one of whose functions was the development of guidance clinics for children. Dr. Douglas A. Thom was made the director of this division. Massachusetts was the first to provide state funds for this purpose. These clinics were to be set up for demonstration purposes for a period of six months and then to be taken over by other community resources. Many of these have been taken over by hospitals and private organizations, but a few are still functioning

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The first three clinics opened by the Division of Mental Hygiene were in Boston in 1923. During the same year, the Worcester State Hospital opened a habit clinic for children. The following year four more clinics were started. The West End Clinic has already been mentioned. Another was the Springfield clinic which, after a year of operation, was taken over by private agencies under the supervision of the Monson State Hospital.

Much of the initial community educational work was done in conjunction with the Massachusetts Society for Mental Hygiene which has always conducted a vigorous campaign.

By the beginning of 1925 four more clinics were opened. One of these, opened at St. John's Hospital in Lowell, was closed in 1927 and the patients were taken over by a local private clinic. Four years later, at the request of the schools and agencies, the clinic was reopened at the Lowell General Hospital and is still functioning. Another, opened at the Boston Dispensary, became a part of their Children's Department and offered training in child therapy for their medical interns. In 1943 the Boston Dispensary Clinic was combined with the Southard Clinic at the Boston Psychopathic Hospital.

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Guidance Association of Worcester.

During the same year one of the most successful of all the Division clinics was opened in Quincy at the Quincy Dispensary. In 1931 it was moved to a school building where it remained until 1943, since which time it has been in the Children's Health Center. This clinic has been expanding steadily and is now being financed in part by community funds through the active participation of a local sponsoring group.

By 1927, there were eight division and four state hospital clinics in operation. Other states were studying and copying Massachusetts clinics. Schools of social work were cooperating with the division by sending students for field work practice. Late in the same year, the Habit Clinic at the New England Hospital for Women and Children in Roxbury, which had been privately operated, became a part of the Division. This clinic operated for sixteen years until it was consolidated with the Southard Clinic in 1943.

In the period from 1927 to 1938, other clinics were opened to service wider areas of the state. Some of these were later taken over by state hospitals who were also extending their services. During this time, the division clinics fell into two categories, the community clinics, those whose referrals were mainly from schools and social agencies, and the hospital clinics, those that were affiliated with hospitals. While the latter had the advantages of medical services, the former spread education through the communities and were rapidly becoming a part of the community life. At this time, special services such as speech therapy, remedial reading and occupational therapy were introduced

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in the clinics. Emphasis was on the normal child and treatment was carried on in most of the clinics. About December 1937, the name was changed from Habit Clinic to Child Guidance Clinic because it was felt that Habit Clinic referred more to the pre-school child and the clinics were now also dealing with older children.

A period of consolidation rather than expansion then set in with the exception of a new clinic established in Brockton in 1938 with the cooperation of the school department which furnished housing and stenographic service. This clinic has expanded rapidly and steadily.

During the early years of World War II, some of the clinics had to be closed because of transportation difficulties and the shortage of personnel. In 1943, a different type of clinic was opened, the Southard Clinic, at the Boston Psychopathic Hospital. The staff was obtained from three clinics which were closed at this time. While some parents might hesitate to bring their children to a clinic housed in a psychopathic hospital, the additional facilities available for more serious cases were felt to be an advantage. In addition to the Southard staff, the Division staff held five sessions[4] weekly and then cut it down to four. In February 1945, the demand for expanded services in the Division clinics outside of Boston became so great that the Division withdrew its staff from Southard to supply the other clinics because it was felt that there were other facilities available in Boston itself.

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At the present time, there are six clinics actively functioning under the Division of Mental Hygiene. Four of these, Lowell, West End, Brockton and Quincy are operated from the Boston office and each clinic services a large area surrounding the city of its location. The demand for services is extremely high and because these are state-supported clinics, the case loads are at a maximum. The Lowell and West End Clinics hold one session weekly placing a tremendous burden upon the psychiatrist so that intensive therapy has to be curtailed. Added services at the Lowell and West End clinics are speech therapy and tutoring.

The Brockton Clinic shows what can be done on a cooperative basis by school and clinic. The clinic has been supplied with a suite of offices in the school department building and has expanded to four sessions weekly. Speech therapy and remedial reading are included in the services offered here. The clinic is also closely supervising the special classes for superior children which the school system has established. All the other agencies in Brockton also work well with the clinic.

The Quincy clinic differs from the others in its physical and financial setup. It is housed in the Child Health Center which is also used by the Public Nurses when the clinic is not in session. This was formerly a private home which has been lent by the library which owns the building and it has been adequately and tastefully furnished through the help of the Quincy Guidance Association, a community organization, which has also obtained community funds to enlarge the clinic program. Occupational therapy, speech correction and remedial reading are available here. This clinic now has two psychiatrists and four sessions weekly.

Referrals to the clinic come from various sources including schools, social agencies, hospitals, physicians, courts, parents and community education talks.

The age limit in the clinics is usually fourteen, but older children are accepted, especially in Brockton and Quincy, because of their affiliations with the school systems.

The team of psychiatrist, psychologist and psychiatric social worker which was established in the '20's has continued to function effectively. The psychiatrist directs the team. In the clinic, after the intake application is made out, the child is first seen by the psychologist who administers an intelligence test. If further personality tests are considered necessary, they are usually given at a later date. A brief report of the results of the test are given to the psychiatrist who then interviews the mother and obtains the developmental history as well as the factors of the problem itself. The psychiatrist sees the child, makes a tentative diagnosis and decides whether the case will be accepted and carried for treatment. The environmental work is the task of the social worker who also obtains the social history. With all this information at hand, the psychiatrist can then make a fuller diagnosis and decide whether she will work with the child or the mother, assigning the other one to the social worker who also can carry on therapy under the direction of the psychiatrist.

At the present time, the Division of Mental Hygiene staff consists of a director, three psychiatrists, five social workers, one research social worker, one full-time and three part-time psychologists and

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CHAPTER III

FACTORS AFFECTING BEHAVIOR

Before entering upon any consideration of the factors affecting behavior in this study, some underlying principles as stated by qualified authorities will be outlined.

Henderson and Gillespie give as the first of three cardinal points in the psychology of children, "the enormous influence of environment on the child's mental processes".[1] By environment they mean "the personal environment of parents, brothers, sisters, teachers and companions".[2] The writer agrees with Dr. Weill[3] that each child in the family has a different environment, but she prefers the term background because that includes factors not directly related to personal relationships, such as sex, ordinal position, etc. which will be discussed further.

Sex, especially in a culture where the masculine tradition predominates, is an important factor to be considered. The belief in the superiority of the male to the female brings with it attitudes of profound influence. In many families, the birth of a male child to carry on the name is sufficient to put the child in a position of

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1 D. K. Henderson and R. D. Gillespie, A Text-Book of Psychiatry (New York: Oxford University Press, fifth edition), p. 539.

2 Ibid., p. 499.

3 Blanche C. Weill, The Behavior of Young Children of the Same Family (Cambridge: Harvard University Press, 1928).

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2 Ibid., p. 499.

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dominance while his sisters are excluded and left to make whatever adjustments they can. There is also often the difficulty which the child has in accepting the role of his or her sex.

Ordinal position and the difference in ages between siblings is another important consideration. The oldest child has the unique position of being the first and the only child. Normally, he has the undivided attention of his parents. If they have centered all their interest in him, he may develop with the feeling that he should always come first. However, if he has been dethroned by the second child, he may be resentful and jealous. There is then a need always to maintain his position and keep ahead of the next child.

The second child has the older one as a pace-maker. He strives constantly to keep up with his older sibling and if he finds the going too tough, may fall back and try to be the opposite in all ways.

The situation of the middle child is particularly hard. He has to struggle to keep up with his older sibling and still keep ahead of the younger one. If he finds himself unable to keep up with the older one, he may ally himself with the younger. Because of the position of the oldest and the youngest, the middle child is often overlooked.

If the child is the youngest, his babyhood may be prolonged because of the parent's indulgence and reluctance to release him from his dependency. The youngest child also never experiences the feeling of being dethroned. The difference in ages between siblings deter-

mines the length of time which they have had to experience whatever their ordinal positions have been.

Intelligence is still another factor. Those with limited capacity meet more frustrations as they are unable to compete with other children of higher capacities and thus respond with varied types of adjustments. Those children with better than average ability may not derive sufficient satisfactions from their regular contacts and may, therefore, find solutions in anti-social behavior. The child with the higher capacity, however, has a chance of finding other compensating satisfactions which the lesser endowed child may lack. Among siblings, this inability of one to keep up with another or the others may create serious problems.

Physical health often plays a part in the child's adjustment. The child with numerous illnesses is often indulged by the parents in their anxiety over his condition. An undue anxiety over his health may be fostered in the child as result. His habit training may be interrupted and he may miss the socializing influences of the companionship of other children. Often there is trauma connected with a serious illness, operation or accident. A physical defect can warp the entire personality.

In the emotional life of the child there are two basic needs:

1. security
2. affection

It is through the parents that the child fulfills these needs. The first consideration, then, is the relationship of the parents to

each other. A warm, congenial relationship between two well-adjusted parents gives the child the love and security he needs. Marital discord can produce reactions of traumatic proportions.

The relationship between the child and his parents is of paramount importance to satisfy these needs and to set the pattern for the child's future relationships with others. Also, "the normal psychosexual development of the child depends upon the actual presence of two living parents, toward whom he can express and work out his instinctual urges of love and hate".[4] Deprivation of these needs may result in reactions which are not socially acceptable. Parental attitudes are important and unwholesome ones can be very damaging. Of the latter, there are three: Rejection, Overprotection and Indulgence.

According to the authorities previously quoted, the rejected child is the unwanted child who lacks the love which he craves. The child who is suffering from what is known as "affect hunger" develops either very aggressive behavior or withdraws completely. In either case, he may have difficulty in relating to others and if he does marry and have a child of his own, the pattern of rejection is often carried on.

Rejection, however, is not always overt and often manifests

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itself in overprotection. Because of the parent's unconscious hatred, the conscious mind is tormented with fears that something will happen to the child and so he tries to protect the child from all dangers, real and imaginary.

Indulgence may be due to the parent's inability to give the child love so he gives him material things instead. It may also be the parent's way of satisfying his own frustrated needs.

Whatever form these attitudes take, they do produce maladjustments in the child.

The next set of relationships the child encounters is that with his siblings. Jealousy of either an older or younger sibling, hostility toward a new baby or the mother because the baby now gets the attention the other child received or regression to infantile behavior to regain the lost attention are manifestations of sibling rivalry.

Leaving the protection of the home, the child's first contacts are with other children. The pattern of behavior he has developed because of the family relationships will be carried over to the new situation. The biggest test of adjustment, however, comes when the child enters school. While the child may have made what to him is a satisfactory adjustment in the home, the school situation can reveal its inadequacies very quickly. Here he has to adjust not only to the teacher and the other children but to the learning situation, the authority and the discipline of the school. This probably accounts for so many referrals in the clinics in the six to nine age group.

A maladjusted child is one whose pattern of reaction is not socially acceptable. These maladjustments are evidenced in the form of symptoms. There have been numerous attempts to classify these symptoms. English and Pearson[5] use the following classification:

A. Anxiety States, including sleep walking and talking, night terrors and phobias.

B. Psychogenic Disturbances of Physiological Functions

C. Disturbances of Social Adaptation
   1. Aggressive Reactions
   2. Inhibitions of Social Behavior
   3. Sexual Perversions

Henderson and Gillespie[6] use this classification:

1. Disorders of personality: Timidity, obstinacy, irritability, shyness, etc.

2. Behavior disorders: Truancy, temper tantrums, lying, stealing, cruelty, food fads, etc.

3. Habit disorders: Nail-biting, thumb-sucking, enuresis, stammering, etc.

4. Disorders of the so-called "glycopenic" variety: Migraine, insomnia, night terrors, etc.

5. Psychoneuroses: Anxiety neuroses, hysteria, phobias, obsessions, tics (some).

6. Psychoses

7. Epilepsy

8. Mental deficiency

9. Mental disorders occurring with, and probably dependent upon, some physical disease, e.g. chorea, encephalitis.

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5 Ibid., p. 65

6 Henderson and Gillespie, Op. cit., p. 558

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3 Ibid., p. 85

4 Henderson and Gillespie. Op. cit., p. 559

The authors add that this classification is for convenience of description only since the same patient may have symptoms in several of the groups.

It is not this writer's intention to discuss these classifications but merely to present them so that the reader can better understand the case discussions which follow.

CHAPTER IV

DESCRIPTION OF THE GROUP

As has been stated previously, the cases in this study represent twelve families and twenty-six children. The figures which follow are based upon these cases and where they agree with annual clinic statistics it will be so noted.

Age

The ages at referral range from three to seventeen and one-half years. Although seventeen and one-half is older than the usual adolescent seen at the clinics, in the two cases where this occurred, both concerned school problems and were seen at a clinic that is closely affiliated with the school system. The highest peak of the group comes at the age of six, with a smaller peak between eight and nine. More than half the children are in the age group from six to nine which is consistent with the general clinic statistics regarding age at referral.

Sex

There are eleven boys and fifteen girls in this group. This small sample is not necessarily representative as the general clinic statistics show that boys are referred more than girls by a ratio of at least two to one.

Intelligence

The intelligence quotients of these children range from 78 to 139. Fifteen cases are of average intelligence while the others are distributed

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as follows: one borderline, one dull normal, five high average, three superior and one not tested. Generally speaking, the clinics do not accept for treatment children below the dull-normal level as their low capacities limit the treatment possibilities, but occasionally exceptions are made. In the one case that was not tested, the patient stopped coming to clinic before tests could be given. Since he is on grade level and is doing well in his school work, he can probably be considered as having at least average intelligence. Most of the group, therefore, can be considered to have at least average intelligence.

Size of Family

Of the twelve families, there are four families of two children, four of three children, one of four, two of five, and one of nine. Thus, one-third brought both or all their children and another third brought two out of the three in the family. In one case, three out of the five siblings were referred. In the family of nine, three children are patients.

Ordinal Position

There are ten first born, six youngest and ten middle siblings in the group. The first born and youngest categories are weighted by the fact that there are four families of two children each in the study.

School Placement and Adjustment

Two of these children are of pre-school age. Of the remaining twenty-four, nineteen are at grade level, although three are failing in

their work. Three children are retarded one year, one is retarded two years and one is overplaced both for his age and intellectual capacity. Of the nineteen cases at grade level, only nine are making a good adjustment in school. In the five cases referred for poor school work, the cause was found to be an emotional disturbance rather than an inability to do the work.

their work. Three children are retarded one year, one is retarded two years and one is overplaced both for his age and intellectual capacity. Of the nineteen cases at grade level, only nine are making a good adjustment in school. In the five cases referred for poor school work, the cause was found to be an emotional disturbance rather than an inability to do the work.

CHAPTER V

CLASSIFICATION AND OUTLINE OF CASE STUDIES

The cases to be discussed in Chapters VI and VII have been arranged in two general divisions. In most cases, there are a number of causative factors which intertwine and there may be some overlapping. Generally speaking, the cases fall into two groups, those where the problems of the children are for the most part due to:

A. Poor personal relationships, including rejection, overprotection, jealousy, indulgence, cruelty, step-parent, ineffectuality of parent and marital discord.

B. Neurotic parent or parents, using the psychiatrist's diagnosis as a determinant.

The outline of the case studies is as follows:

1. Family history and relationships.

2. History of first child referred and a description of his problems.

3. History and description of problems of subsequent siblings referred.

4. Discussion of treatment whenever pertinent.

5. Analysis of the factors in the total backgrounds of all the siblings of that family.

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CHAPTER VI

CASES INVOLVING POOR PERSONAL RELATIONSHIPS

Case 1. Mary and Charles Cook

This is a Protestant family consisting of the parents and four children, two girls and two boys. Father, a business school graduate, has been a manager in a large series of chain stores. He is interested in his children, likes outdoor activities and often takes Charles with him when he goes out. Paternal grandfather is a successful lawyer and has done much for the family financially and otherwise. Father has worked in various stores of this chain and the family has moved eight times in the past ten years. Mother is an affectionate person who enjoys life and tends to take things easy. There appears to be a warm happy family relationship here.

Mary, an attractive, healthy-looking seven-year old girl of normal intelligence, was referred by the school in October 1943, because of a reading difficulty after an eye examination was negative. Mary is the third child and five years older than the baby. The family sees no other problem but clinic examination reveals an insecure, timid child. In school she was promoted to the second grade although not ready. Her teacher feels that there is no reading disability, only a slowness in learning to read. She is being given extra help and is learning. The teacher is more concerned about Mary's attitude in school. She is not interested in anything and is very restless. She yawns a great deal and acts as if she were tired. She does not enter into playground activities with the other children and seems immature. She entered kindergarten when she was five and it was during this year that Warren was born.

At home she is quiet and well mannered. She has many toys and can entertain herself well. She plays school and teacher often. She is not as aggressive as her siblings, but gets along well with children and has playmates her own age. Discipline is shared by both parents, but mother tends to be lax. However, the children appear well-behaved and well-trained.

Two weeks later, Charles, a nice-looking, wholesome-appearing ten-year old boy was brought to clinic by his mother because of nocturnal enuresis. He wets about four times a week. At the age of two he had pneumonia. His toilet training was interrupted and he has never been really

dry since then. He becomes angry with Mary but on the whole gets along well with his siblings. He is grandparents' favorite.

The school reports that both he and the second sibling, Edna, are adjusting well and doing good work. They are very different from Mary. Charles' school attendance is irregular and it is felt that the parents are not careful about the children's attendance. Charles goes to the toilet more frequently than is usual, but the school physician says that he be allowed this.

Psychological tests were not given because Charles attended clinic only once and then refused to return because he felt he was too old and did not want to miss school.

Mary was known to the clinic over a period of eight months. A private tutor was secured and her school work improved. There was a slight improvement in her attitude. Mother was working and lost interest in coming to clinic. It was the feeling of the school and clinic that mother was somewhat lax and irresponsible in her attitude toward school.

Mary's problem is more severe and may be due to the fact that she was the baby for five and one-half years until she was supplanted by her baby brother. She exhibits a pattern of behavior which may be connected with masturbation or the giving up of this habit. Charles, as the first born and a male, indulged by his grandparents, may be enuretic because of faulty toilet training. The numerous changes in residence and the parents' lack of responsibility for the school situation have added to the instability. Both of these children were indulged, Charles as the first and Mary as the baby for a long time. Their behavior may be the result of their wish to remain babies.

While these children do not present severe behavior problems, there is a laxity and a lack of steady, firm control in this family which has produced an insecurity in both these children. The second child was brought to clinic either at the suggestion of the clinic

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staff or because the mother learned that the clinic also treated problems other than the reading difficulty for which the first child came.

Case 2. Nancy and Evelyn Minetti

This is a Catholic family consisting of the parents and three children, two girls and a boy. The boy is five months old and there is about three and one-half years difference between each child. Father, thirty-nine, American of Italian parentage, is an electrician in a war plant. He is the type who enjoys his home and is inclined to spoil the children by making excuses when they misbehave, such as "they are tired or not well". Mother, thirty-three, is very stout but when she tried to diet she became very irritable. She is excitable and flies off the handle easily. She worries about the home and her inability to get her housework done. She is unable to handle the children and is inclined to be prudish. The parents are happy together and there is a close relationship with maternal and paternal relatives.

Both Nancy and Evelyn were referred to the clinic at the same time, in February, 1943, by the family physician for thumb-sucking and behavior. However, the problems revealed were different. Nancy's problems were destructiveness, lying and jealousy of Evelyn while Evelyn revealed a speech difficulty and shyness.

Nancy is a slim, dark haired, olive skinned, "cute" little six-year old girl. She looks like the Italian side of the family and resents it. She indicates superior intellectual capacity and during the psychological examination she demonstrates that she knows exactly what she can and cannot do. She uses a disparaging tone toward Evelyn. Nancy is the first born in a family of three. She was the first grandchild and during her first three years was completely spoiled by the maternal grandmother and aunts. Now that there are more grandchildren, Nancy misses this attention.

Birth was premature and by instrument. Development was normal, although she was breast fed for only three months. At the age of four, she had a T and A in a hospital and had night terrors for a while afterward. She has had no sex information. Thumb-sucking has persisted from birth. She is destructive and untidy in order to annoy mother and is rude to her. She ridicules mother and laughs at her. She imitates mother but disrupts the house. For example, she oils her doll like mother oils the baby but she messes up the place in the

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process. She is very jealous of Evelyn and wants everything bigger than Evelyn's. She is very mischievous and leads Evelyn into mischief. Nancy plays well with children her own age and has many friends. She has to be "boss" but they accept it. She lies imaginatively. Father leaves disciplining to mother who cries and becomes upset when Nancy misbehaves. Mother usually gives in and caters to her. Finally, however, mother loses patience and spanks her.

Nancy attended nursery school last year, liked the teacher and received a medal for being the best child.

Evelyn is a cute, round-faced, stodgy little three-year old girl, built like mother. She has a rather solemn expression on her face. She is of average intelligence although there was a question of a possibility of a higher score as it was hard to understand her because of her serious speech defect. She was good-natured and cooperative.

She is the middle child in a family of three and is the second girl. She gets Nancy's hand-me-downs. Birth was normal. She was bottle fed and development was slow. She did not talk until she was two years old and has never talked well. She has had pyelitis all her life. She has been sucking her thumb since birth.

Mother says Evelyn is easier to handle than Nancy. She is calmer and more placid and obeys mother readily. Evelyn is rather shy but she enjoys when Nancy is noisy and she follows Nancy into mischief. Evelyn stays by herself more as there are no girls her age in the neighborhood. She trails after the bigger children but does not care if they pay her no attention. She is content to play with her doll, carriage and bicycle.

Treatment consisted of helping mother with child management and training. The thumb sucking decreased and mother felt that she had learned to manage the children better.

Nancy was badly spoiled during her first three years as the only child and first grandchild. She strongly resented Evelyn's birth and is extremely jealous of her and the new baby. Nancy is older and brighter and the leader of the two. Her behavior is geared toward attracting attention. While thumb sucking in a three year old is not

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a serious problem, its persistence in both children would indicate a lack of satisfaction or an inability to adjust. Evelyn's speech difficulty, which is not clearly described in the record, may be her attention-getting mechanism. The difference in their personalities is due to Nancy's position as the first child and the subsequent spoiling whereas Evelyn has been relegated to second place.

Both of these children have been poorly handled and trained and as a result, sibling rivalry is the cause of much of their difficulty in adjusting. The behavior of both of these children was sufficiently disturbing to the mother who took them to a physician who in turn referred them to the clinic.

Case 3. Amy and Carol Stuart

> This is an Episcopalian family consisting of father, step-mother and two children, both girls. Father, forty-six, is a college graduate and is a sales executive. He is easy-going, mild and has an excellent disposition. Mother was selfish, care-free and irresponsible. The children were allowed to run wild without adequate supervision. Father secured a divorce on the grounds of adultery when Amy was seven and Carol was eleven. The children lived with the paternal grandparents for a few years. When father married stepmother, they took the children to live with them in a different city where father was working. Stepmother is a college graduate, a social worker and interested in civic activities. She is objective and lacking in warmth and is dutiful toward the children but not affectionate. She has set too high standards for the children and is too strict with them. Parents aspire to college educations for the girls.
>
> Amy, the younger, a plain, blond-haired, well-groomed, twelve-year old girl, was referred to clinic by her stepmother in May, 1942, because of deceitful and lying behavior. Problems revealed were stealing from stepmother and sister and also nail biting. On the intelligence tests she earned a score of 103. Personality tests revealed a very naive and childish individual with an immature attitude toward reality which is covered by a veneer of polish and savoir faire.

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She lies a great deal to save trouble but often these lies are rather stupid and pointless. Her stealing has been confined to small amounts from stepmother and sister. She is a friendly, adaptable, good-natured youngster who gets along well with adults. She plays with younger children so that she can boss them. She has a bicycle and enjoys outdoor activities. Discipline usually takes the form of deprivation of some pleasure but is effective for only a very short time. She gets along well with Carol but shows no deep feelings for anyone . Father fears that Amy may follow mother's example of irresponsibility. Amy likes school and gets good marks. She goes to Sunday School but has not yet been confirmed because parents say that she has not enough moral sense.

Stepmother asked for help in her relationship to the children. Psychotherapy was given to stepmother and Amy. The parents' ambitions and too high standards were explained. At the end of eleven months of contact, Amy's symptoms disappeared and she was making a good adjustment.

In November, 1943, Carol, seventeen and in her last year of high school, was referred by stepmother for psychological appraisal and vocational guidance. Problems revealed were shyness, timidity and feelings of inferiority. She had changed from a college to a secretarial course because she could not keep up with the former but she still wanted to go to college. Her I. Q. was 102.

Carol had been her mother's favorite and both girls had been visiting mother during their summer vacations. This practice was discontinued because it was too unsettling and disturbing to the girls.

Carol works after school daily and Saturdays and also has to help with the housework. She is trying to attain higher standards than she is mentally capable of achieving and has too much work and responsibility thrust upon her.

Treatment was not undertaken. Carol's limitations were explained. Parents found a Junior college that was within her ability and she is doing very well there. Amy has improved even more since Carol is away and Amy has her own room.

These two insecure children are the products of a broken home where mother was carefree and irresponsible and no adequate training was given. The change from a lax home to one of ultra respectibility

and rigid standards was too difficult for them to accept. Amy, the younger of the two, was rejected by her mother while Carol was the older and the favorite. Amy had had no real experience with love and was jealous of both her sister and stepmother. She expressed her hostility by stealing from them. As she became more secure in the home her symptoms disappeared. Carol was being pushed beyond her capacity but while Amy, who had been deprived of affection, showed an aggressive reaction, Carol withdrew into a shy timid personality.

These two children, from a home broken by divorce, with lack of adequate training, combined with rejection of one child and favoritism toward the other, when brought into a new home with a stepmother and too rigid standards, were unable to make the necessary adjustments. In this case, the stepmother was helped with one child and so brought the second child.

Case 4. Betty and Marilyn Barnes

> This is a Protestant family consisting of the parents and three children, two girls and a boy. Both parents came from broken homes. Father has always worked hard and earned a steady but small salary. He alternates day and night shifts. He is not demonstrative, is a stern disciplinarian and bites his nails. Mother took college entrance examinations but could not afford to attend college. She therefore went to normal school and gave piano lessons. She feels superior to father but says she is not sorry she married him. She has high standards for herself and the children. She likes people and is active in many clubs. She is a frustrated individual who has been burdened with many responsibilities. Paternal grandmother, who was an interfering person, lived with parents from the time of their marriage. She had angina and cancer and then developed a senile psychosis. She died when Betty was four. A paternal uncle, who is ill, irritable and annoyed by the children's noise, also lives in the home.

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For a time, a maternal epileptic aunt also lived with this family.

Betty, the oldest, a pretty, well-built eight-year old girl, was brought to the clinic by her mother because of negativism, facial tic and diurnal enuresis. Mother was mainly concerned with Betty's defiant attitude toward her. Mother thinks Betty is "very bright". Psychological tests give an I. Q. of 103. Additional problems revealed were finger sucking, nail biting, hysterical screaming and crying and vague fears. Betty was toilet trained at one and one-half years, during the day. Nocturnal enuresis persisted until the age of six. The diurnal wetting and facial tics began about six months previous to referral. She has had no sex instructions and has exhibited no curiosity. Paternal grandmother spoiled her and interfered with her training. Betty is not affectionate but gets along well with adults and children. She belongs to many groups and enjoys outdoor active play. Mother denies sibling rivalry and says all Betty's hostility is directed to mother.

Betty is correctly placed in the third grade in school which she likes. Her marks are good and she is neither a follower nor a leader. She does not wet in school and teacher did not notice any tic until mother mentioned it. The teacher feels mother is too exacting.

About two months after Betty's referral, mother brought in Marilyn, the second child, a stocky, round-faced, little three and one-half year old girl with an I. Q. of 100. For the past year she has been pulling out her hair so that her hair is now sparse and there are a few bald spots. Other problems were finger sucking, nocturnal and diurnal wetting since birth, wandering and temper tantrums until a year ago. She is very mischievous and always getting into trouble. When she was one year old she burned her arm and for a while had night terrors. In the beginning she used to cry whenever she saw mother holding her baby brother. Now she plays that he is a doll. Mother has never been able to train Marilyn as far as the wetting is concerned.

It was felt that this mother might accept treatment if it were put on the basis of challenging her intellectual capacity. This family was seen over a period of ten months. In the meantime mother became pregnant but came to clinic until her condition would no longer allow it. The children were much improved and mother felt that the clinic contact had been of great benefit to all three of them.

Betty, the first born, has been identified by mother with paternal grandmother who spoiled Betty and toward whom mother was antagonistic. Six months after the loss of grandmother another child was born and Betty was thus deprived of all attention. Mother has been frustrated in all her ambitions and because of her desire to be superior has overestimated Betty's abilities. Betty's reversion to enuresis is an expression of her hostility to mother and jealousy of her siblings. Marilyn, the second child, was the baby for only a little over a year when her brother was born. As the middle child she has had little training and, as her symptoms would indicate, no satisfactions. Her hair pulling started when she gave up her temper tantrums which indicated a deprivation or lack of affection.

The problems of these two children are a result of a poor hereditary background and home situation where too much is expected of them and there is much family interference. The spoiling of the first child and the subsequent sibling rivalry are important factors. In this case, having been helped with one child, the mother referred the second child.

Case 5. Mildred, Sue and Ralph Carter

> This is a family of nine children, three of whom are known to the clinic. Father is a Protestant; mother, Catholic; and the children follow mother's religion. Father was in the Navy for seventeen years. He now has chronic myocarditis and is around the house most of the time. He walks the floor continually and is hot tempered and irritable. He drinks to excess and becomes silly and very talkative but not abusive. Mother, untidy and unattractive, was deprived as a child because grandfather was alcoholic. Mother used to be stubborn when she was small. She appears to be moderately intelligent

but overburdened. She is somewhat dramatic and enjoys the attention which Mildred's difficult actions bring. The parents have little or no recreation. The family income is substandard and the home is shabbily furnished and dirty. The nine children range in age from two to twenty-two. The oldest and youngest are boys.

Mildred, the sixth child, a pretty, eight-year old girl, shabbily dressed in untidy and colorless clothes was referred to clinic in January, 1939, by the hospital medical clinic because of lying and stealing. Problems revealed were poor school adjustment, poor relationship with teacher and boys, violent temper, stubborness, restlessness, nail biting, quarreling with siblings, poor sleep and masturbation in school. Her I. Q. was 110 but it was felt that she could have done better if not so conflicted. She is very much of a tomboy but has difficulty in her relationship with boys. She wishes she were a boy. She is very aggressive in her contacts in the home and outside. She quarrels a great deal with her next older and next younger siblings. Mother says she is very much like father with her lying, stubbornness and lack of dependability. Father protects her when she lies. She identifies and is identified with father.

Mildred did well in school until this year when she was blamed and punished for everything by the teacher. The principal admitted that this teacher was hypercritical and he changed Mildred's class. She is doing much better with the new teacher although she is anxious for attention, speaks out of turn and tells tales. She is socially and economically below the level of the other students and therefore feels insecure and inferior. Her lying is both protective and imaginative. She stole money at home but always admitted to it.

At the end of nine months of treatment her adjustment in school and at home had improved. It was felt that this was due not to changes in the family attitude but to Mildred's responsive attitude. Eight months later the case was reopened because of day dreaming and carelessness in school. However, they failed to keep subsequent appointments so the case was closed.

Two and one-half years later, in December, 1942, mother brought Sue, a colorless eight-year old girl, to clinic because of poor school work. She is failing the third grade work and the school wants to know whether to demote her now or let her finish and then repeat the year. Sue has low average intelligence and her achievement tests were on second grade level. She has a long history of illnesses,

starting with three of the children's diseases before she was one year old. She has been in convalescent homes and Children's Island numerous times. As a result she was spoiled because no one in the family could say "no" to her. She has a shy, tense manner and is very restless. She sucks her little finger no matter where she is. Her sleep is restless and her speech infantile. She is said to be a good mixer. Sue is too immature but it is felt that grade two would be too easy for her now so the recommendation is made for repetition next year. Mother is now working and asked for help only with this one problem.

Mother also brought Ralph, five and one-half years old, and the youngest member of the family, for the same reason as Sue. He was six days too young for the first grade but passed a test and was accepted. However he is too immature, is always tired and refuses to do his work. The school wants to demote him. He is an undersized, attractive boy, very much of a verbalist. He is of low average intelligence. He is dependent upon mother but she cannot see this. She maintains that although he is extremely active, he is no problem at home. He dresses, washes and feeds himself, is very popular with other children and is not spoiled. He has had numerous accidents. He burned his foot when he walked into a fire with his shoes on, saying he was Superman. He also fell off an eighteen foot wall and was hospitalized for three days. He was not unconscious nor was he seriously injured. He is adventurous and wanders off but he always gets home and tells where he has been.

Ralph came to clinic only for psychological appraisal for school placement. The diagnosis was an immature child, overplaced in school. It was felt that he would react poorly to his demotion at this time so it was recommended that he finish the year and then repeat.

Mildred, a middle sibling of perhaps better intelligence than the others, exerts herself more and is therefore more outstanding in the family. She presents a picture of very aggressive behavior in revolt to her position in the family and as an expression of her resentment at their difference from others in the neighborhood. Her identification with her alcoholic father creates great insecurity and her wish to be a boy coupled with her poor relationship with them

indicates a difficulty in her psychosexual development.

Sue presents a picture of an immature, insecure, spoiled child due to her many illnesses. Ralph, the baby and his mother's favorite, is typical of the spoiled, dependent baby of the family about whom mother can see no problem.

This is a very unstable and inadequate home on a low financial level, with an alcoholic father and an ineffectual mother. Identification, in the case of Mildred, and spoiling due to many illnesses in one child and the position of the baby in the other, play an important part in the maladjustments of these siblings. The maladjustment of these three siblings has shown up in the school situation and thus outside pressure forced the mother to bring the children to the clinic.

Case 6. Allen and Grace Wilson

> This is a Protestant family consisting of the parents and five living children. Father was born in England. At the age of nine, when grandparents were divorced, he was placed out where he had to work for his room and board and so developed independence at an early age. He expects the same independence of Allen and berates him for the lack. Father is very stern, strict and irritable and the children are afraid of him. He is interested in studying and is always taking courses. He is intelligent but extremely slow in expressing himself. Mother has limited intelligence and understanding. She has tried hard to study and keep up with father but finds his interests too technical. There is much friction in this home. Father says mother is "dumb" and Allen is just like her. There is also much friction between mother and paternal grandmother upon whom father is quite dependent.
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> Allen, the oldest, is a very small, thin boy of eight who was referred to clinic in October, 1936, by the school principal because of poor school adjustment and inattention. Other problems revealed night terrors, fears and poor social adjustment. He is very timid and tires easily. Noise and

indicates a difficulty in her psychosexual development.

She presents a picture of an immature, insecure, spoiled child due to her many illnesses. Ralph, the baby and his mother's favorite, is typical of the spoiled, dependent baby of the family about whom mother can see no problem.

This is a very unstable and inadequate home on a low financial level, with an alcoholic father and an ineffectual mother. Identification, in the case of Mildred, and spoiling due to many illnesses in one child and the position of the baby in the other, play an important part in the maladjustments of these siblings. The maladjustment of these three siblings has shown up in the school situation and thus outside pressure forced the mother to bring the children to the clinic.

Case 6. Allen and Grace Wilson

This is a Protestant family consisting of the parents and five living children. Father was born in England. At the age of nine, when grandparents were divorced, he was placed out where he had to work for his room and board and so developed independence at an early age. He expects the same independence of Allen and berates him for the lack. Father is very stern, strict and irritable and the children are afraid of him. He is interested in studying and is always taking courses. He is intelligent but extremely slow in expressing himself. Mother has limited intelligence and understanding. She has tried hard to study and keep up with father but finds his interests too technical. There is much friction in this home. Father says mother is "dumb" and Allen is just like her. There is also much friction between mother and paternal grandmother upon whom father is quite dependent.

Allen, the oldest, is a very small, thin boy of eight who was referred to clinic in October, 1935, by the school principal because of poor school adjustment and inattention. Other problems revealed night terrors, lying and poor social adjustment. He is very timid and tires easily. Noise and

confusion bother him very much. In the psychological tests he was dull, apathetic and very slow in his responses. He earned a score of 93 but showed many inconsistencies.[1]

In school he is in the third grade and has done well until this year. Now he dislikes both school and the teacher. The teacher is high strung and so there may be a personality clash here. He is lazy, listless, tardy and negativistic. He sticks things into other children and quarrels with them, causing much confusion in the classroom. No method of discipline is effective. He showed a tendency toward using his left hand but with much pressure he was converted to right-handedness by mother. He was born one month prematurely but otherwise his development was normal. He has always had a fear of fire and has been having night terrors since he saw a fire during the night a few months ago. He is slow in dressing and mother has to help him. He dislikes any activity involving physical strength and avoids a fight if at all possible. He will not enter into group activities but prefers being alone and amusing himself. He enjoys reading. He is very good at home and mother often leaves him to care for the younger children. Mother spanks him because father believes the strap is the only effective measure. Mother disagrees because she feels that patient only withdraws and is not reached. Allen is the favorite of paternal grandmother who indulges him. He is identified with mother by both his parents yet he follows much of father's behavior pattern. Father rejects him so mother overprotects him. Mother excuses him because she says he has a "complex" because of his small size. She realizes that the home situation is the cause of his school failure.

Allen was known to clinic for nineteen months. His school behavior improved but not his work. The psychiatrist tried unsuccessfully for almost two years to reconstruct the family attitudes and also direct therapy with Allen. Because of the lack of cooperation from the family, the case was closed. The case was reopened in April, 1943, at the request of the school. He was no longer a behavior problem but was doing no work at all. He was pushed ahead to the eighth grade although not ready because otherwise he would be in the same grade as his next younger sister, Emma. He is absent frequently on the pretext of illness and mother always makes excuses. Father is now a Captain in the army. In September

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1 When he was retested six years later his I. Q. was 99.

of the same year mother said Allen was in high school and doing satisfactory work so that she would prefer that he not return.

At this time, at the psychiatrist's suggestion, mother brought in Norma, ten, who is also making a poor school adjustment. She is repeating the fourth grade but still failing in arithmetic. On the psychological test she shows high average ability but the uneveness of her performance indicates emotional disturbance. She is an attractive, shy little girl and the third child. At the age of four she had scarlet fever which left her with some impaired hearing. She is nervous, is easily upset and cries over nothing. Because of her failure in school she feels inferior. She does not mix well with other children. She visits her grandmother during the summer and gets along well there. Mother says father, Allen and Norma are alike. A crowd fusses them and they enjoy being alone.

Arithmetic tutoring and a hearing test were recommended. However there were only six contacts including clinic and school visits. In March, 1944, Norma's school work had improved and she was going to be promoted so mother saw no need for further visits.

Allen is the first born and for eight years, the only boy. He held the position of first child for only a short time as his next sibling, a girl, is only one year younger. This increased the rejection he felt from his father who himself was rejected. A premature birth with a first child suggests the possibility of a forced marriage. Mother's indulgence may be due to overcompensation for her own rejection, identification with Allen or a reaction to father's rejection. Allen's own identification with his rejecting father has created a severely disturbed boy. Norma, a middle child and the second girl, shows a similar type of response. She is extremely sensitive to father's sterness and the friction in the home. Since no complaint has been made about the other siblings, it can be assumed that they

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are making better adjustments than these two children who have been unable to withstand the severity of the home situation and so have withdrawn into themselves.

Constant family discord, identifications and rejection combined with these two children's inability to express their feelings toward their dominating father have caused a withdrawal on their part which has shown up especially in the school situation. The second child here came to the clinic at the suggestion of the psychiatrist.

Case 7. Robert and Martha Adams

This is a Protestant family consisting of two children, a girl and a boy whose parents are divorced. Mother has remarried and the children live with her. She divorced father because of sexual and physical abuse, promiscuity and lack of support. Father, thirty-three, has a terrible temper and was abusive to the children. He visits them about once every two months but has to see them outside as stepfather will not allow him in the home. The children used to be afraid of father but now they go with him although they are not fond of him. He contributes to their support. For a time after the parents separated, the children were shifted back and forth between the parents and several foster homes, finally coming to live with mother. Mother, thirty-five, an unattractive and poorly groomed person, is inferior and inadequate. As a child she felt rejected by her parents and was shy and afraid of people. She is easy-going but worrisome. Stepfather, thirty-five, is an unattractive, thin nervous man who is ill at ease and stammers a bit. He is calm and easy-going but the children obey him. He feels mother is not strict enough with the children but he does not want to punish them. The family income is small. They live in a poor neighborhood and Robert has to sleep in the kitchen while Martha has her own room. In this second marriage, while there is no friction, there is no warmth for the children.

Robert, the younger child, a good-looking, blond, curly haired nine-year old boy of dull normal intelligence, was referred to the clinic by the school principal in January, 1943, because of uncontrollable bursts of temper and creating tense scenes in the classroom. Added problems were

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overactivity, nail biting, jealousy, fighting and general irritability. He is in the second grade and is doing passing work. His behavior has created a problem. He goes into temper tantrums, is stubborn and impertinent. He cannot take criticism or rebuke and shows a great need for attention. He is not popular with the other children although they accept him and play with him. He repeated the first grade because of the many changes in residence.

At home he also displays a temper, is stubborn and is constantly quarreling with his sister. He is restless and tosses in his sleep. He was toilet trained early but wets the bed about once in three weeks. He is fascinated by fire.

Two months after Robert's referral, mother brought Martha to clinic because of stubborness and over-sensitivity. Problems revealed were constant quarreling with Robert, thumb sucking at night, crying without provocation, shyness and hand twitching when talking. Martha is a thin, blond-haired, gentle-looking, eleven-year old girl of average intelligence. She does not look healthy. She talks in her sleep and dislikes dogs. She is very shy with strangers and does not get along well with other children. She prefers playing by herself with her dolls and sewing for them. The chief problem is the constant quarreling with her brother. They strike and deliberately annoy one another. Martha is the only one who mentions her father and writes to him. The period when she lived with him seems to have made her older and to have created a divided loyalty.

Martha is in the fifth grade and is an average student. She is shy and sensitive but sweet and willing and therefore the school considers her no problem at all. She gets along fairly well with the other children, although she is not popular, and plays normally in school games.

Treatment was centered mostly around the attendance of both children at Hobby Class which was part of the occupational therapy work. Their mutual interest gave them something in common so that the quarreling abated. Martha also joined a Scout Troop which helped broaden her interests and brought her into contact with other girls. Both showed improvement, especially Robert. At the end of fourteen months his overactivity, general irritability and temper were much improved and he appeared a much happier child.

Here are two children reacting to a similar situation with entirely different personality patterns. Robert's aggression is overtly

expressed while Martha's shy, withdrawn personality conceals a tremendous amount of hostility. Martha, the older and a girl, identifies with her mother who was shy and afraid. Robert, on the other hand, has identified with his father and has copied his pattern of behavior. Martha may also identify Robert with father and her hostility toward her brother may be the expression of the hostility she feels toward her father. Martha's attachment to her father is an added complication.

There has been very little affection or guidance in the lives of these two children. Father was cruel and entirely inadequate and mother appears to have little to offer these children. Sibling rivalry runs high as they both bid for mother's love. These are two emotionally disturbed and insecure children, the products of a broken home complicated by the mother's remarriage. Here again, help with the first child brought the second.

In the foregoing cases of poor personal relationships, the factors listed under this heading in Chapter V are brought out. Rejection, indulgence, sibling rivalry, cruelty, family discord, ineffectuality of parent, inadequate training, lack of affection, step-parents, spoiling and pushing the child beyond his capacity are evidenced in these cases. Ordinal position, sex, intelligence and health, coupled with the aforementioned factors have determined the behavior and personality patterns displayed by these siblings according to which combination of factors had the strongest influence on each child. In six out of the seven families in this group, the siblings present different personality reactions and patterns. In the remaining case,

that of the Wilson family, while both of the children are of the withdrawn type, they differ from their other siblings and in their reactions to many situations they differ from each other.

In all these cases, there is an imbalance in the relationships of the parents to each other or to the children and between the siblings themselves as to create sufficient maladjustment to bring these children to the attention of a child guidance clinic. In five of the seven cases, the second child came to the clinic either at the suggestion of the clinic staff or because the mother was helped with the first child. Of the two remaining cases, one mother was sufficiently disturbed by the children's behavior to bring both siblings at the same time. In the other case, the children's difficulty in the school situation forced the mother to bring the subsequent siblings.

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CHAPTER VII

CASES INVOLVING NEUROTIC PARENTS

Case 8. Donald and Arthur Smith

This is a Christian Scientist family consisting of the parents and three children, all boys. For the past few years family finances have been on a substandard level and as a result father's disposition has grown steadily worse. He is extremely tense, highly explosive and constantly creating scenes in the home. He was the youngest in his family, was overtly rejected by his father and, as a result, indulged by his mother. Mother appears to be an intelligent and understanding person with better control than father. However, she too demonstrates a great deal of instability. She was the youngest and the favorite in her family until she renounced the Catholic religion and left home at the age of eighteen. She has a long hospital medical record revealing an irritable, nervous person with an overdoing drive. Because father is overstrict mother tends to be lenient and protective of the children. The same pattern of rejection by the father and indulgence by the mother appears again. John, the middle son, is easy going and not bothered by father's temper.

Donald, the oldest, an attractive ten-year old boy of superior intelligence, was referred to the clinic in April, 1940, by the medical department of a hospital because of severe twitching of the arms, hands and face which had developed about a year previously. Other problems revealed were poor sleeping habits, nail picking, hypersensitivity and crying.

He is a gregarious youngster with varied interests and activities. He has many friends, enters into group activities and is a leader. He has a strong physical resemblance to his father and is active in athletic activities in which his father excells. Donald has been getting an allowance since he was three years old and now earns twenty-five cents a week helping father who is the superintendent of an apartment house.

Birth and development were normal. Shortly after his birth, an application was made to a social agency to have him boarded out because mother was too ill and nervous to care for him. Nursing help was arranged instead. He has had a number of the children's illnesses and when he was eight, a T and A

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He is a precocious youngster with varied interests and activities. He has many friends, enters into group activities and is a leader. He has a strong physical resemblance to his father and is active in athletic activities in which his father excells. Donald has been getting an allowance since he was three years old and now earns twenty-five cents a week helping father who is the superintendent of an apartment house.

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was attempted but not done. He has also had bronchitis and many stomach upsets. There was a question of cyclic vomiting at one time and his twitching was at first thought to be early chorea.

Donald is affectionate but feels he is now too old for display of affection. He is extremely jealous, especially of his siblings. Being the oldest, he feels he should come first and wants to be the recipient all the time. He says his brothers are being favored when they get things. Gaining his father's approval is very important to Donald. If father reprimands him or sends him to bed as punishment, he bursts into tears and carries on for some time. About a year and one-half previously, father had complained to the hospital that Donald was copying mother and becoming overconscientious and nervous.

In school, he is in the fourth grade, has always been an honor pupil and is well liked by all. This year he changed schools and is in a higher level class so that it is harder for him to maintain his usual high marks and his work has slumped somewhat.

Mother cooperated with the clinic to the best of her ability. After eight months of contact, Donald's twitching completely disappeared and he was back on the honor roll. Father had a new job and the family situation eased somewhat.

Three years later, in 1943, Arthur, the youngest, then almost seven, was referred to the clinic for psychological appraisal by a child placing agency. Summer camp was being considered and there was the possibility of permanent placement. Physically, he is the opposite of Donald. At clinic he, at first, clung to his mother and cried and whined. Later he became boisterous and very active. His I. Q. was 95 and he appeared very immature. Mother is completely unable to manage him. He steals, is very destructive at home and recently started a fire in the back of a theatre but no damage was done. He has wandered away since he was little and mother has to go looking for him. He stands on the railroad tracks and throws stones at the trains. He associates with older boys who are delinquent and gets into bad scraps with other children in the neighborhood.

Shortly after clinic contact was terminated with this family in 1940, mother became ill and Arthur was placed in a foster home while his brothers were sent to Children's Island for a period of time. Father has been in the Navy since 1941 but has been able to visit the home frequently. Mother

appears frail, extremely high strung and tense and completely unable to manage Arthur.

Since Arthur was brought to clinic for diagnosis only, a report was sent to the referring agency. The clinic psychiatrist also questioned the possibility of an organic basis for his behavior.

Each one of these three children presents a different picture. Although John was not seen as a clinic patient, that in itself is important. Donald as the first child wants to maintain this position. He identifies with his father, yet he has absorbed much of mother's anxiety. With his superior intelligence he is able to attain satisfactions outside the home but he seems to be driven by an urge to be first in everything. When he was thwarted he developed a tic which is a symptom of internal tension. John, as the middle child, appears to have placed himself outside the family conflict and to have made some adjustment of his own. Arthur was born at a time when the family strain was the greatest. He may have felt the brunt of his father's violent outbursts since he early started the pattern of running away. He lacks the intellectual capacity and the satisfactions of his oldest brother. There is a lack of ego development which is manifested by his destructive and pre-delinquent behavior.

The problems of these children arise from a very difficult family situation complicated by many illnesses, financial difficulties, a neurotic father and unstable mother. Ordinal position and intelligence are important factors here. Both these children were referred by outside agencies.

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Case 9. Betty Lou and Edward Gordon

This is a Jewish family consisting of the parents, maternal grandfather and three children, two girls and a boy. Father is ill and has worked irregularly so that supplementation from a welfare agency has been necessary. He was operated on for phlebitis, but even after his physical condition was negative, he still complained of pains in his legs which led to a tentative diagnosis of a psycho-somatic complaint. He evidences maladjustment in his home life and his work. Mother is an intelligent but very confused individual. She is disappointed in marriage, never wanted any children and would rather go to work. She has held some good jobs which she had to give up as each child was born. Maternal grandfather, seventy-three, lives in the home. He has a violent temper, is super-critical and upsets the entire household. Mother has always hated him. He nags until mother becomes negativistic and she is repeating the same pattern with Betty Lou.

Betty Lou, the oldest, a cute, dumpy little girl of seven, of high average intelligence, was referred to clinic by the Children's Hospital in December, 1941, because of masturbation. Other problems revealed were thumb sucking since the age of two, nail biting, irritability, super-sensitivity, some food capriciousness and jealousy. She masturbates by rocking in a chair and calls it "riding up and down". She does this especially in school when she is given work which she does not like. Her attention is so diverted that she does not finish her school work. She entered nursery school at the age of three. Mother says masturbation started when Betty Lou was three and mother left her with paternal grandmother while she went to work. This was also the time of the birth of Edward, the second child. The masturbation subsided and was fairly infrequent until a few months ago when the new baby was born. While she is said to be fond of Marion, the baby, she is extremely jealous of Edward and is bossy toward him. There is a constant rivalry between the two older children which is aggravated by mother's attitude. Mother says she has never really enjoyed Betty Lou since she was born. Mother did not know anything about handling children and was afraid to hold Betty Lou. Father had to help her. Betty Lou was "brought up by the book" and no one was allowed to pet or cuddle her. She is now an unhappy child who becomes upset and cries easily. Mother says she was like this as a child and she also had a younger brother.

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family for a number of years was giving them case work services, the clinic withdrew. However, in December 1943, while Edward was being seen at clinic, mother brought Betty Lou back because she had begun to masturbate again. Some environmental help was given. It was felt that mother was in need of treatment but she was so disturbed about finances that the case was again transferred to the family agency because these difficulties would have to be straightened out before therapy could be effective.

Shortly before Betty Lou's first visit to clinic in 1941, Edward had been referred by his nursery school teacher but mother felt that the teacher was exaggerating the problem and so refused to come. However, in July 1943, his kindergarten teacher at summer day camp was so insistent that mother finally brought him to clinic because of his school conduct. He is a tall, good-looking six-year old boy of superior intellectual capacity. He is so big that he looks like an eight-year old. The teacher reports that he does not get along well with the other children. Recently he grabbed another boy by the neck and nearly choked him. He twists the children's wrists, lies and is very disobedient. He cannot conform to the group but mother cannot appreciate the importance of this. He was in nursery school for two years and used to cry every morning when first left there. It took him a long time to adjust. At first they thought him too quiet and urged him to be more aggressive and defend himself. Father taught him to box and now that he is too aggressive, mother blames the school. Mother feels that the teacher is prejudiced because Edward at home is not at all the way the teacher describes him. "He is the most lovable and affectionate of the children." However he does have night terrors, many fears, and for the past two months has been wetting the bed. In the clinic, he acts very silly and cuddles up to mother who is extremely affectionate with him. He resists all efforts to get him to join in any group activities there. Mother says he imitates Betty Lou too much and blames Betty Lou for their rivalry. While Betty Lou is bossy toward him, it is noted that he cannot bear to have any attention directed toward her.

Mother "loves to complain" according to the psychiatrist. She reacts negativistically to any suggestions made. Edward was seen at clinic over a period of seventeen months. A slight improvement was noted. The case was closed at the same time as his sister's for the same reason.

Betty Lou, the first child and a girl, identifies with her mother who rejected her even before her birth. Her symptoms and

behavior indicate tension and difficulties in her relationship with her parents. She is a very unhappy child and must have tremendous guilt feelings. She is jealous of her brother and her aggression toward him is overtly expressed. Edward, although the second one, is a male child who has been thoroughly spoiled by his mother who refuses to see him as a problem at all. Mother pours affection on him and is seeking the satisfactions from him which she has not found in her husband or her marriage. Edward is a timid child with many fears for which he is forced to overcompensate by his aggressive behavior outside the home.

These are two neurotic children of neurotic parents. The rejection of one child is aggravated by the lavishing of affection on another and sibling rivalry is very much in evidence. Both these children were referred by outside agencies. In the case of the second child, the mother refused to see him as a problem but the pressure of the school forced her to bring him to the clinic.

Case 10. George and Lewis Winters

> This is a Catholic family broken by divorce and complicated by the remarriage of the mother. There are two boys, one living with the mother and one with father. The hereditary background is poor with a history of tuberculosis and kidney trouble in the paternal family and of tremors and "nervousness" throughout the maternal family. Father, who was converted to Catholicism, is neurotic and alcoholic. He beat mother and the children unmercifully and never supported them. Mother has never been well. She had chorea at the age of fourteen, now has severe blinking and grimacing and is "nervous" like the rest of her family. She appears to be extremely self-centered and childlike. Stepfather is a foundry worker and good to George. Mother calls him an ideal husband. The income is marginal. Mother has a great deal of guilt about

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This is a Catholic family broken by divorce and complicated by the remarriage of the mother. There are two boys, one living with the mother and one with father. The hereditary background is poor with a history of tuberculosis and kidney trouble in the paternal family and of tremors and "nervousness" throughout the maternal family. Father, who was converted to Catholicism, is neurotic and alcoholic. He beat mother and the children unmercifully and never supported them. Mother has never been well. She had chorea at the age of fourteen, now has severe blinking and grimacing and is "nervous" like the rest of her family. She appears to be extremely self-centered and childlike. Stepfather is a country worker and good to George. Mother calls him an ideal husband. The income is marginal. Mother has a great deal of guilt about

going contrary to her religion.

George, the younger, a thin, stooped boy of nine, was referred to clinic by his teacher in December, 1941, because of poor self-control, roughness and nervousness. Other problems revealed were poor eating and sleeping habits, twitching, stubborness, meaness and poor physical condition. He has an I. Q. of 78. He is in the third grade, having repeated the first. He is overplaced for his mental capacity yet teacher says his work is average. His concentration is poor. He plays rough at recess, is mean to the other children and pinches them. He is prompt and regular in his attendance and obeys the teacher immediately.

Beside the trauma of his father's abuse, George has had numerous illnesses and several operations. At the age of three months he was operated upon for pyloric stenosis and was on the danger list for nine weeks. Last year he was hospitalized for a mastoid.

Father rejects George and will have nothing to do with him. There is a strong physical resemblance between the two and mother taunts George with "you're just like your father, a bum". When George becomes stubborn mother either gives in or loses her temper and slaps him. Mother also gives in if he goes into a temper tantrum. He is very rude to stepfather. George has only one friend, a smaller boy whom he dominates. Mother says George is good morally and is so modest that he will not undress in front of anyone. He refuses to go to bed until very late and is therefore tired in the morning. He eats between meals and still eats well at meals. He goes to Mass and Sunday School every week and wants to be a priest.

After eight months of contact the case was closed. The school situation was unchanged although there was slight improvement at home. Because of patient's and mother's limited capacities it was felt that no further service could be rendered.

In September, 1943, Lewis, a tall, dark, thin, fourteen-year old boy with a pleasing manner, was referred to clinic by the county probation officer for psychiatric study for placement or treatment. Other problems were stealing, tics, setting fires, sex play with girls and unmanageability. He has been stealing since he was small but has no court record as yet. His tics are in imitation of mother. He is of average intelligence.

At the time of parents' divorce, Lewis was given in

custody to his father. Lewis was placed in a Catholic boys' institution from which he ran away several times. He then went through a series of foster home placements with and without father. When sober, father was very good to Lewis, took him fishing and bought him many things but when drunk, he still beat Lewis. Father died suddenly in an automobile accident in November, 1942. Lewis shed no tears for him. Again there was a series of foster home placements. Stepfather refused to have him in the house because he could not stand Lewis.

Lewis is now living near mother's home, in a home where he once boarded with father and to which he went on his own initiative. The home is undesirable and the morals bad. Mother wants him placed away from this city immediately because he insists upon visiting frequently and she says he influences George. Mother rejects him completely and fears if he stays in the community he will get into trouble and also break up her present marriage. Lewis realizes his mother's rejection. He is very jealous of George and they fight constantly. Lewis is cruel with younger children because he says they make him nervous so he hits them to get rid of them. He is rough, reckless and unhappy and feels he belongs nowhere. He has no friends, no future and no particular interests except an abnormal interest in sex.

He is in the seventh grade. His school progress is almost impossible to follow because of many changes. He has repeated grades twice. Now he is not interested in school and does no work. He shows an aptitude for trade training.

Treatment was not undertaken by the clinic because of the many factors involved. An institutional placement in a predominantly male atmosphere plus psychotherapy was recommended although the prognosis was poor. After a period of four months a children's agency finally arranged to have him admitted to Children's Village.

George, the younger, although hampered by his poor intellectual capacity, was subjected to his father's abuse for a shorter period of time. Although his mother is ambivalent toward him, wavering between rejection because he is like his father and overprotection because he is her only child and she wants to keep him a child and dependent, he, at least, gets some affection from her and has a home with a substitute

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father. George's rejection of stepfather may be his reaction to any male figure or he may resent the man who has partly supplanted him in mother's life. Lewis, on the other hand, being older, has for a long period of time received the full brunt of his mother's rejection and his father's ambivalence and abuse. There have been frequent changes of homes and he has had no opportunity for ego development with the resultant delinquent behavior.

These two boys are the products of poor heredity and have suffered severe trauma at the hands of two neurotic, rejecting parents who finally broke up the home by divorce. In this case, both referrals came from outside sources. The second child was exhibiting delinquent behavior and so the community, through the probation officer, stepped in.

Case 11. Paul, Roger and Dorothy Strong

> This is a Protestant family consisting of the parents and five children in a very poor home and family situation. Father, a factory worker, is an irresponsible and ineffectual person and a procrastinator. About six years previous to the first referral father had had an affair with another woman. It was straightened out but there has been much unhappiness in the home since then. Mother, a slovenly, careless person, is emotionally unstable and has frequent periods of depression when she cannot stand the children around her. She is disappointed in her marriage and projects her complaints on the children. She is more anxious for help for herself than for the children and has had psychiatric treatment in the past. The home is primitive, cluttered and inaccessible except by automobile since they live about three miles from the center of town. This town is also some distance from the clinic. Mother would bring several of the children with her to clinic disregarding their colds, tiredness or frequent lack of breakfast.
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> Paul, the third child, a nice-looking, blond-haired,

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Paul, the third child, a nice-looking, blond-haired,

very shy, six and one-half year old boy, was referred to clinic in April 1942, by the hospital medical department after an eye test proved negative, because of eye rubbing and blinking and inattention in school. Additional problems were irritability, occasional nocturnal enuresis, crying easily, friction with his older brother and unhappiness. His I. Q. was 107 with a possibility of a higher score. There was much day dreaming and a high degree of instability noted.

Paul does not get along well with his siblings as they are always picking on him, especially Roger, and there is much friction between the two boys. Paul has no particular interests, although he likes outdoor play but prefers to be by himself. Paul is tense and reflects mother's emotional condition. In school, his marks are good except for effort. He is not interested and is very slow in everything. He is not a problem but seems seclusive. The teacher compares him unfavorably with Ethel and Roger who are fine, alert pupils.

In all the time that mother came to clinic she was more concerned about Ethel, fourteen, than she was about Paul. Ethel, however, refused to come to clinic. Ethel, who had been brought up for several years in her grandmother's home, became very defiant upon her return and insisted upon having her own way. There was continual friction with mother who was jealous of father's pride in Ethel.

A year later, while Paul was still being seen, mother brough Roger, a thin, pale eleven-year old boy, to clinic because he was nervous. He was always quarreling with his siblings, would accept no responsibility at home and had a history of many illnesses. He had an I. Q. of 125 but was lifeless and showed no enthusiasm. His illnesses started at the age of two months and culminated in an appendectomy four months before referral. His school work was always good but slumped after the operation.

Both cases were closed in November 1943. Roger's general physical condition improved but his problems remained the same. Paul's blinking cleared up a short time after he started to come to clinic. At the end of treatment he showed some improvement in school and began to mingle a little better. Mother felt he was doing as well as he could and she was more concerned about Ethel anyway, so she decided not to return.

However, in September 1944, mother returned with Paul who was still quiet and subdued but more outgoing than he had been. He received "the best report card in the family" but mother was concerned that his teacher was not good for him.

Mother then brought in Dorothy, a wholesome, attractive girl of seven, who was doing poorly in school. Mother complained about the teacher and wanted Dorothy transferred. Dorothy entered the first grade at the age of five and one-half and did well. She was promoted to a mixed second and third grade and was failing. Her I. Q. was 102. Although with the psychiatrist she appeared spontaneous and not reflecting of her mother's moods the way Paul did, she began to cry for her younger brother when she failed some of the harder tests. She also revealed poor eating habits, a fear of the dark and mice about which her younger brother John teased her.

Mother failed to respond to appointment cards and so the cases were closed.

Mother is a very disturbed person in need of treatment who projects her complaints on the children, yet wants all the attention for herself. Ethel, although not seen at clinic, is the first born, a girl and her father's favorite. Her period of living away from home brought the home situation into sharper focus. As a result there is a tremendous antagonism between her and mother which is aggravated by Ethel's adolescent struggle for independence. Roger, the second child but the first boy, because of ill health has been spoiled and is very jealous of his siblings, especially Paul, the next younger. Roger lacks energy and is unable to use his superior intellectual ability. Paul, the middle child, the butt of his brother's sbiling rivalry, is the closest to mother and reflects her emotional condition. Dorothy, the fourth and next to the youngest, had only a short period of being the baby before she was ousted from this position. Her lack of satisfactions have created an insecure little girl. One can speculate that with this neurotic background, the youngest child, while he may never be seen at clinic, will probably develop into another behavior problem.

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This is a very inadequate and unstable home, physically and emotionally. Identifications, rejection, spoiling due to illness and sibling rivalry are factors in this neurotic background which determine the behavior and personality patterns of these siblings. This mother's attention-seeking for herself plus the pressure of the children's school difficulties have brought the subsequent siblings to the clinic.

The following case has been included in this category because the mother's mental illness is more closely allied with neuroticism than with the previous classification.

Case 12. Ruth and Helen Jones

> This is a Protestant family consisting of the parents and two girls. Father, sixty, is a tired, careworn, ineffectual man who has always worked hard and earned little. He was born in Canada and is not a United States citizen although he has been here many years. Father is a milkman and has irregular hours so that breakfast is at 11 A. M. and dinner may be as late as 9 P. M. This is father's second marriage. Mother, forty-one, is mentally ill. She has a very unstable family background and says she has always been sick. She says she has heart trouble and cancer. She is preoccupied with illness and fears of death. She has paranoid delusions. She is always writing letters and has deluged the clinic with them. The home is poor and inadequate. This is a very disorganized household.
>
> Ruth, the younger child, is a beautiful five-year old girl with a sophisticated manner and an amazing vocabulary. She has an I. Q. of 139. She was referred to the clinic in November, 1940, by the Children's Hospital as a "problem child" and because for the past year she has been sucking her nightgown. Problems revealed were poor sleeping habits, food capriciousness, negativism, night terrors, quarreling and poor physical history. She had spina bifida and at the age of seven months a successful operation was performed. Mother, however, has told her that she is very delicate and must be very careful. As a result she has been having all kinds of psycho-somatic pains. She is an exceptionally bright child and is always showing off and demanding

attention. She gets along well with other children but mother prefers to keep her at home and keep her dependent upon mother. Ruth is thoroughly spoiled and quarrels with Helen. Ruth thinks she can do whatever Helen does and Ruth copies Helen's sophisticated ways.

This family was known to clinic for a period of four years. A year after referral, Ruth entered the first grade in school. At first she cried and mother asked that she be sent home from school if she did not feel well. She was doing superior work but said she was bored with school. She disliked arithmetic and refused to do it. She was autocratic toward the teacher. At clinic she attended occupational therapy classes but was bored. She was very aggressive with one of the boys in the class, kissing and hugging him and calling him her boy friend.

Mother was referred to a neuro-psychiatric clinic where a thirty day period of study in a state hospital was recommended but father was unable to carry through on this.

Later when Ruth was recommended for the special class for gifted children the parents decided against it because of her poor health and transportation difficulties.

In October, 1943, Helen, then seventeen, was seen at clinic at the request of the mother and the school. The problem as stated was poor home and school adjustment. Helen is a plain looking, tall, thin, shabbily dressed girl. She came to clinic with an air of boredom and hostility which covered a tremendous insecurity. On the psychological tests she earned a score of 117 with a possibility of its being higher. She has always been a problem in school because of frequent absences on account of supposed illness. Her marks however were good. At home there was much friction between mother and Helen because Helen identified with father. She had few friends and her main hobby for about four years was astronomy.

The situation became acute a few months previous to the referral when Helen eloped with a forty-five year old discharged soldier whom the parents had taken into the home. She was the aggressor because she wanted to get away from her home situation. After a month of living in a distant city under very bad conditions, she allowed herself to be brought home while her "husband" remained there. Since her return she has been surly, defiant, uncommunicative and resentful. She has threatened to commit suicide. Because of her age, she had to return to school. The school asked

the clinic to assist with Helen's adjustment so that she could combine junior and senior class work and graduate with her class. A few months later Helen became ill with a high fever and joint pains. Mother was resentful because the focus was taken away from her. Helen had good insight regarding her mother. The clinic tried to get Helen out of this influence and wanted to place her in a foster home but this plan was not carried through. She was unable to complete the school work and the following year she remarried her husband.

Much time was spent with this family and intensive psychiatric treatment was tried with mother and the girls but little was accomplished in changing this family's attitudes.

Ruth, a beautiful child of very superior intelligence, the younger of the two by nine years, was completely spoiled by mother. Ruth's anxiety about physical illness, the dependence upon mother and the attention getting behavior made a change of attitudes impossible. Helen, by contrast, was plain looking, rejected by her mother and identified with her ineffectual father. She became shy and withdrawn and when she could no longer bear the situation tried to solve her problem by running away.

These two children are the products of a psychotic mother and an ineffectual father. There is much emphasis on illness, complicated by the interplay of identifications, rejection and favoritism. The mother's own need for treatment combined with the children's school and community maladjustment caused both of these children, especially the second child, to come to clinic.

In all the preceding cases, the neurotic parent or parents have created maladjustments in the children. Because neurotics are sick people, they have greater difficulty in effecting wholesome

personal relationships and, therefore, neurotic parents will create more serious difficulties in their children. There is a great incidence of physical illnesses and preoccupation with ill health, whether real or psycho-somatic, in the parents and children of this group.

In all these cases, the behavior and personality patterns of the siblings are different. There was little, if any, response to treatment because of the severity of the problems.

Of the five families in this group, three were two-children families so that all the children were patients. In the three-children family, the youngest was only an infant, but the two older children were seen. In the remaining family, where there are five children, the youngest was still a baby, the oldest whom mother considered the greatest problem refused to come to clinic, and the middle three children were all patients. The complex family situations due to neurotic parents have created such severe problems and maladjustments in these children as to result in bringing almost all the children in these families to the clinic for treatment. It would thus appear that the more disturbed the family situation, the more need there will be for more than sibling to seek treatment.

It can also be seen that all these children manifest such difficulties in their adjustment outside the home that these outside sources have either made the referrals themselves or have brought pressure to bear so that the mothers have brought the children themselves.

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CHAPTER VIII

SUMMARY AND CONCLUSIONS

This study was undertaken because of the writer's interest in trying to determine what it is that brings more than one sibling for treatment to a child guidance clinic. Thirty-nine cases which were opened in the year 1943 and where a previous sibling had been known to the clinic were examined with the following criteria:

1. Cases in which another sibling was known to the clinic.
2. Cases with a full social history to give sufficient background material.
3. "Closed" cases, those in which treatment has been terminated.

Of the thirty-nine cases, only twelve conformed to the criteria selected for this study.

The first question asked was, "What are the factors in the backgrounds of these siblings and are they the same?" From this study, it can be seen that the interplay of the factors of ordinal position, sex, intelligence, health and lack of security and affection combined with the forces of the various relationships have made a separate and different background for each sibling. There is not enough similarity in the backgrounds of these siblings to make that the reason for the coming of the second child to the clinic.

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The differences in personality patterns were found to be the results of the difference in the background of each sibling. The responses of these children to even some similar influences were not

always the same. In the cases in this study, the personality patterns of these siblings range from the shy, seclusive, withdrawn type to the overtly aggressive delinquent. In eleven of the twelve families studied, the siblings show different personality patterns. In the twelfth case, both children are seclusive and withdrawn. This may be due to the fact that there are five siblings in this family, and the two who were studied may have had similar identifications and may have been subjected to many of the same influences. However, these two children differ from their other siblings and in their reactions to many situations they differ from each other.

No generalization can be made from the range of types of personality patterns. However, the interplay of the previously mentioned factors in the backgrounds of these siblings has resulted in such maladjustments as to cause these children to come in conflict with others either in the home or outside. They have in common that they are all in undesirable family situations from a mental hygiene point of view. Their behavior has become disturbing enough either to the parents or to outsiders, the school especially, so that help must be sought. It would appear that the factors at work in these families have created such severe problems and anti-social responses that a need for treatment has arisen in more than one child. Where there are neurotic parents who themselves are seriously maladjusted, it can be expected that the children also will be seriously disturbed. In this group of families with neurotic parents, almost all the children were seen at clinic.

On the basis of the cases studied here, several reasons for the referral of a subsequent sibling were revealed. In six out of the twelve cases, the children manifested such difficulties in their adjustment outside the home that, whether or not the parents recognized the problems, these outside sources, the school especially, either made the referrals themselves or brought pressure to bear so that the parents brought the subsequent siblings. Two of these six cases were further complicated by the mothers' seeking attention for themselves because of their own need for treatment. In five of the remaining six cases, the second child came to the clinic not by referral by outside sources but at the suggestion of the clinic staff or because the mother was helped with the first child. In one case, both siblings were brought to clinic at the same time because the mother was disturbed by the children's behavior.

While it can be seen that the factors in the backgrounds of these siblings have created maladjustments in these children of such proportion as to bring about a need for treatment, there is no evidence to show that it is these factors or any combination of them which caused more than one child from a family to come to the clinic.

Since these conclusions are based on such a small sample and since the reasons given in the case records for subsequent referrals are not fully set forth, the writer would suggest for further study a larger sample of children from the same families to see whether the findings of this study as to backgrounds and reasons for referral of more than one sibling are further substantiated.

This writer would also like to recommend to the Child Guidance Clinic: (1) that with future referrals of a subsequent sibling, more emphasis than at present should be placed upon the reason for bringing a subsequent sibling and (2) that a fuller study be made of the various backgrounds for the purpose of determining what it is that brings more than one child to the clinic.

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APPENDIX

Schedule

Number Name Sibling

Age: Address:

Clinic and date of referral:
By whom:
Problem:

Results of psychological exam:

Family history:
Paternal:
Maternal:
Siblings:
Others in the home:
Marital situation:

Position in family:

Physical description:

Developmental history:

Health:

Habits:

Personality:

Relationships with siblings and others:

Play life:

Environment:

Economic situation:

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